

d. State the names of State employees whom you claim were at fault, including any information that will assist in identifying and locating them.

e. State the negligence or wrongful acts of the State agency and State employees which caused your damages.

f. State the name and address of all witnesses to the accident or occurrence.

g. State the names of all police officers and police departments who investigated the accident.

Claim for Damages (check appropriate block)

Personal Injury Property Damage

Other – Explain in detail

If you claim personal injury:

1. Describe your injuries resulting from this accident or occurrence.

2. Do you claim permanent disability resulting from this injury:

Yes

No

If yes, describe the injuries believed to be permanent.

3. For each hospital, doctor or other practitioner rendering treatment, examination or diagnostic services, state:

Name of hospital, Doctor or other Facility	Address	Dates of treatment or service	Amount of charge to date	Amount paid or payable by other sources, i.e. insurance
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If you claim wages or income as a result of the injury, state:

Name of employer	Address of employer
Your occupation	Date you became employed
Rate of pay	Dates absent from work
Total lost wages to date	If still out, expected date of return

NOTE: If your claimed loss of income arises from self-employment or other than wages, attach a calculation showing the basis of your calculation of lost income.

If you claim property damage:

1. Describe the property damaged.

2. The present location and time when the property may be inspected.

3. Date property acquired _____

4. Cost of property \$ _____

5. Value of property at time of accident _____

6. Description of damage _____

7. Has the damage been repaired? _____ If so, by whom, when, and cost of repairs: _____

8. Attach each estimate of repair costs to this form.

9. Set forth in detail the loss claimed by you for property damage.

10. Set forth in detail all other items of loss or damages claimed by you and the method by which you made the calculation.

11. The amount of the claim. _____

a. Have you made a claim against anyone else for any of the losses or expenses claimed in the notice?

b. If yes, set forth the name and address of all persons and insurance companies against which you have made such claims.

12. Are any of the losses or expenses claimed herein covered by any policy of insurance? _____
For each such policy, state the name and address of the insurance company, policy number and benefits
Paid or payable. _____

13. Have you received or agreed to receive any money from anyone for the damages claimed herein? _____
If so, set forth the details of such agreement.

14. The following items must be submitted with this notice:
- a. Copies of itemized bills for each medical expense and other losses and expenses claimed.
 - b. Full copies of all appraisals and estimates of property damage claimed by you.
 - c. Copies of all written reports of all expert witnesses and treating physicians.
 - d. A letter from your employer verifying your lost wages. If self-employed, a statement showing the calculation of your claimed lost income.

I hereby certify that the foregoing statements made by me are true, that the attached statements, bills, reports and documents are the only ones known to me to be in existence at the time. I am aware that if any statement made herein is willfully false or fraudulent, that I am subject to punishment provided by law.

Dated: _____

Claimant or person filing claim on behalf of
claimant.

I hereby authorize any and all doctors, hospitals or other medical service facilities to release to the State of New Jersey any and all records, reports and other information concerning the treatment of the claimant named herein.

Date

Signature